

NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2003

RE: MDR Tracking #: M2-03-0837-01
IRO Certificate #: IRO4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ____ when she was bending and pulling some drawers. The patient is status post-thoracic fusion at T11-12. A CT myelogram of the thoracic spine reveals moderate left paracentral spur formation/hard disc noted at T12-L1 with right lateral pedicle screw fixation. She has been treated with trigger point injections and physical therapy. The patient has complaints of pain at the site of her surgery at T11-12 and mid to upper back pain.

Requested Service(s)

Bilateral thoracic facet injections at T8-9, T9-10, and T10-11

Decision

It is determined that the bilateral thoracic facet injections at T8-9, T9-10, and T10-11 are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has complaints of thoracic pain status-post work related injury with residual pain following a T11-12 spinal fusion. The patient has significant thoracolumbar junction pain and it is standard of care to treat this type of pain with facet injections to the appropriate areas. This patient's symptoms should respond to the prescribed treatment. Therefore, the bilateral thoracic facet injections at T8-9, T9-10, and T10-11 are medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,